doi: 10.1111/1753-6405.12994

Do alcohol price control measures adequately consider the health of very remote Australians?: Minimum Unit Price in the Northern Territory

Sarah Clifford,[1] James A. Smith,[1,3] Elizabeth Adamson,[1,2] Tessa Wallace[1]

1. Wellbeing and Preventable Chronic Diseases Division, Menzies School of Health Research, Northern Territory
2. Social Policy Research Centre, University of New South Wales
3. Charles Darwin University, Northern Territory

Alcohol is one of the leading preventable causes of death and disability worldwide[1] and its harmful use is especially problematic within the Northern Territory, Australia. Alcohol-related harms may be categorised as either lifetime harms, which can include chronic liver disease, diabetes, heart attack and cancer; or single occasion harms, which can include assault, suicide and self-inflicted injuries, and road traffic injuries.[2] Both lifetime and single occasion harms are disproportionately noted among those living in very remote locations; according to the Australian Statistical Geography Standard (ASGS) Remoteness Structure, Darwin is outer regional, Katherine and Alice Springs are remote, and the rest of the Northern Territory is very remote. Of those living in both outer regional and very remote Northern Territory locations, 29% drink at levels that place them at risk of lifetime harm, and 43% of individuals living in very remote Northern Territory drink at levels that place them at significant risk of harm on a single occasion at least monthly.[3] As a comparison, in the major cities of Victoria, Australian Capital Territory, South Australia and New South Wales, only 14–15% of people drink at levels that put them at risk of lifetime harm, and 22.5–24% drink at levels that place them at risk of harm on a single occasion.[3] Recent estimates indicate that harm caused by alcohol-related incidents costs the Northern Territory approximately $1.38 billion a year.[4]

One of the most effective policy responses is price control, with strong evidence to suggest consumption decreases as price increases.[5] There are two major forms of alcohol excise taxes: *ad valorem*, which is a percentage of the price prior to sale tax; and specific tax, which is a predefined sum per unit of alcohol (also called volumetric tax).[6] Minimum Unit Price (MUP) is another economic measure, which involves setting a minimum price at which alcohol can be sold. Evidence from Canada and the UK suggests that an MUP is likely to reduce consumption and related morbidity and mortality[7] as a complementary strategy to taxation.

Minimum Unit Price in the Northern Territory

While the Commonwealth Government enforces a complex national system of alcohol taxes, the Northern Territory has previously implemented additional price controls (Living with Alcohol Program 1995; Alice Springs Liquor Supply Plan 2006), which have been credited with reductions in consumption, alcohol-related Emergency Department presentations and antisocial incidents.[8,9]

After the Northern Territory Alcohol Policies and Legislation Review[10] was released in 2017, the Northern Territory Government began an epoch of concerted investment in alcohol harm minimisation. The enactment of the *Liquor Amendment (Minimum Pricing) Act 2018* (now superseded by the revised *Liquor Act 2019*), ensured that from 1 October 2018 no unit of alcohol (one standard drink; which contains 10g of ethanol) could be sold for less than $1.30.[11] It is worth noting that the original recommendation suggested a MUP of $1.50.[10] This was based on modelling that suggested this value was likely to yield the largest reduction among individuals consuming at harmful levels, rather than those consuming moderate levels.[12] The MUP was eventually reduced to $1.30 due to industry pressure and perceived public palatability.

As a result of a qualitative evaluation of another universal Northern Territory alcohol policy intervention known as the Banned Drinker Register (BDR), commentary about the MUP arose, which suggested that in all very remote locations, freight costs had already ensured prices were above $1.30 per unit. These locations are sparsely populated, and they have numerous health and social pressures that are compounded by poorer access to services compared to urban centres.[13] At this juncture, it is useful to cast an equity lens over universal alcohol policy development in diverse jurisdictions to highlight its limitations.

Universal policies in remote settings

Although the MUP is a population-wide harm reduction measure, due to pre-existing high prices in very remote areas it may have overlooked the people who live in those locations in the Northern Territory, the majority of whom are Aboriginal and Torres Strait Islanders.[14] As a result of social and economic disadvantage, poor housing and overcrowding, low levels of education, and the legacy of colonisation, this is a population group who experience disproportionate levels of alcohol-related harm.[3,15] As price control is considered to be the most effective policy response for reducing alcohol consumption, there is an important question regarding how price control policies account for cost differences between urban and remote areas. While there are additional policies that apply in some very remote areas in the Northern Territory and render substantial areas 'dry' or alcohol-free, there must be a distinction made between prohibitionist policies and price control policies, as the latter has substantially more international evidence to suggest reductions in harm.[5,6] It is also essential to reiterate that these 'dry' restrictions do not apply in all areas classified as very remote. The risks of lifetime and single occasion harms in these areas are substantial[3] and this has not been accounted for in the implementation of the Territory-wide MUP.

The authors have stated the following conflict of interest: The Menzies research team has received funding from the NT Government for alcohol policy evaluation work. That work has informed this commentary.

Marmot's concept of proportionate universalism rejects the notion that impartiality must be expressed through uniformity. Rather, it supports the offset of structural disadvantage through the provision of additional resources to disadvantaged groups.[16] Using the tenets of proportionate universalism, a MUP could differ across regions to account for existing price variation. Proportionate universalism would involve a MUP being implemented with a proportionate increase in the floor price of alcohol, in alignment with the cost of alcohol prior to implementation; put simply, a scaled MUP based on geography. Alcohol price control measures in the Northern Territory – and more equitable health outcomes – could be strengthened by scaling the current MUP in recognition of existing freight costs, alongside additional interventions that are both targeted and equity-focused, to accommodate the heightened vulnerability. This would require modelling that recognises existing price disparities across regions prior to implementation.

Conclusion

In the case of the MUP, other jurisdictions could learn from this implementation and should consider conducting modelling that accounts for existing price differences before applying a standard MUP. Adjusting for this by applying a proportional universal price control measure may have a greater chance of impacting health inequities and being effective at a population-wide level.

References

1. Griswold MG, Fullman N, Hawley C, Arian N, Zimsen SR, Tymeson HD, et al. Alcohol use and burden for 195 countries and territories, 1990–2016: A systematic analysis for the Global Burden of Disease Study 2016. *Lancet*. 2018;392(10152):1015-35.
2. Miller PG, Coomber K, Staiger P, Zinkiewicz L, Toumbourou JW. Review of rural and regional alcohol research in Australia. *Aust J Rural Healt*h. 2010;18(3): 110-17.
3. Australian Institute of Health and Welfare. *Alcohol and Other Drug Use in Regional and Remote Australia: Consumption, Harms and Access to Treatment 2016–17*. Canberra (AUST): AIHW; 2019.
4. Smith J, Whetton S, d'Abbs P. *The Social and Economic Costs and Harms of Alcohol Consumption in the NT*. Darwin (AUST): Menzies School of Health Research; 2019.
5. Miller P, Curtis A, Chikritzhs T, Toumbourou J. *Interventions for Reducing Alcohol Supply, Alcohol Demand and Alcohol-related Harm: Final Report*. Canberra (AUST): National Drug Law Enforcement Research Fund; 2015.
6. Meier PS, Holmes J, Angus C, Ally AK, Meng Y, Brennan A. Estimated effects of different alcohol taxation and price policies on health inequalities: A Mathematical Modelling Study. *PLoS Med*. 2016;13(2):e1001963.
7. Boniface S, Scannell JW, Marlow S. Evidence for the effectiveness of minimum pricing of alcohol: A systematic review and assessment using the Bradford Hill criteria for causality. *BMJ Open*. 2017;7:e013497.
8. Stockwell T, Chikritzhs T, Hendrie D, Fordham R, Ying F, Phillips M, et al. The public health and safety benefits of the Northern Territory's Living with Alcohol Programme. *Drug Alcohol Rev*. 2001;20(2):167-80.
9. Symons M, Gray D, Chikritzhs T, Skov S, Saggers S, Boffa J, et al. *A Longitudinal Study of Influences on Alcohol Consumption and Related Harm in Central Australia: With a Particular Emphasis on the Role of Price*. Perth (AUST): Curtin University National Drug Research Institute; 2012.
10. Riley T. *Alcohol Policies and Legislation Review*. Canberra (AUST): Government of the Northern Territory; 2017.
11. Secombe PJ, Stewart P, Brown A, Bailey MJ, Pilcher D. The impact of an alcohol floor price on critical care admissions in Central Australia. *Med J Aust*. 2020;212 (5):229-30.
12. The Foundation for Alcohol Research and Education. *The Price is Right: Setting a Floor Price for Alcohol in the Northern Territory*. Canberra (AUST): FARE; 2017.
13. Australian Institute of Health and Welfare. *Rural and Remote Health*. Canberra (AUST): AIHW; 2017.
14. Australian Bureau of Statistics. *Estimates of Aboriginal and Torres Strait Islander Australians, June 2016*. Canberra (AUST): ABS; 2018.
15. Boffa J, Tilton E, Ah Chee D. Preventing alcohol related harm in Aboriginal and Torres Strait Islander communities. *Aust J Gen Pract*. 2018;47:851-4.
16. Carey G, Crammond B, De Leeuw E. Towards health equity: A framework for the application of proportionate universalism. *Int J Equity Health*. 2015;14:81.

Correspondence to: Ms Sarah Clifford, John Mathews Building, Royal Darwin Hospital Campus, Rocklands Dr, Casuarina, NT 0810; e-mail: sarah.clifford@menzies.edu.au